SATURDAY, MARCH 15, 1873.

ORIGINAL LECTURES.

LECTURES

ON THE SURGERY OF THE NARES, LARYNX, AND TRACHEA.

BEING THE MÜTTER LECTURES FOR 1872.

Delivered before the College of Physicians of Philadelphia,

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Reported by R. M. BERTOLET, M.D.

LECTURE IV.

(Continued from page 355.)

ŒDEMA of the larynx is a very serious affection, on account of its liability to produce suffocation. Such a result has been known to occur at the very first evidences of the attack, before there had been any opportunity of establishing a diagnosis. Hence it is essential to be able to recognize the condition promptly and to treat it efficiently, lest temporizing treatment may sacrifice a patient whose life ought to have been saved. The obstruction in breathing is at first limited to inspiration, and is caused by the atmospheric current pressing inwards the tumid folds of membrane; but, as the disease progresses, expiration also becomes impeded.

When the œdema is dependent on acute disease, the suffocative paroxysms will be abrupt, violent, and occur irregularly at intervals of a few hours. When it is the result of chronic disease, the dyspnœa gradually increases until it culminates in a paroxysm of suffocation, which passes off with more or less relief to the respiration, to recur, as the disease progresses, at irregular intervals, which steadily grow shorter, until several paroxysms occur within the twenty-four hours, being, as a rule, more violent at night than in the daytime. In sub-glottic œdema the breathing is apt to be still more noisy, much like that occurring in laryngismus stridulus.

The best treatment for œdema of the larynx consists in making incisions into the swollen tissues. This affords egress to the pent-up fluids, and generally arrests the threatening symptoms immediately. This operation may be performed readily with a long curved bistoury, protected to within a short distance of its point, and directed to the parts by the guidance of the finger upon the seat of swelling. When the laryngoscope can be employed, Gibb's or Tobold's laryngeal knife affords much greater security in operating, and in great measure obviates the danger of wounding parts that should not be cut into. The spasm produced by the operation is usually insignificant. There is not, as a rule, much blood lost; but occasionally the bleeding is profuse, requiring the most assiduous efforts on the part of the patient to expectorate the blood entering the larynx, so that, despite the relief to the general dyspnœa, the patient has to cough for his life. The external and internal application of ice for a few minutes will generally suffice to restrain any alarming bleeding. Where the bleeding is but slight, it is often to be encouraged by a warm-water gargle or the inhalation of steam. After scarification the parts as seen in the laryngoscope present a wrinkled appearance, with bloody marks of the incisions.

A second scarification in cases of acute œdema is rarely requisite, especially when the progress of the disease can be watched with the laryngoscope, so as to be combated by less serious measures; but where the œdema is the result of chronic affections of the larynx, the operation may have to be repeated frequently. If the infiltration has made progress towards solidification, as sometimes happens, this operation will be ineffective, as it is only when the effused products are fluid that they can escape through the incisions. Under these circumstances, should the urgent symptoms of the condition persist, unmodified by the local results of the scarification,—such as the hemorrhage attendant upon it, the relief of the tension, etc.,—the operation of tracheotomy should be performed. This will save the patient for the time being, and allow him eventually to recover if there has been no fatal congestion of the lungs or brain, for the operation does not always succeed in rescuing the patient. Two instructive cases of this kind, followed by fatal results, are recorded by Drs. Pitman and Page.* The impeded respiration, if the operation be delayed, will have prevented due arterialization of the blood, and have thus induced congestion of the brain; a condition from the effects of which the patient may be unable to rally, even though he survive for a few hours, perhaps days, without further impediment to respiration. To be successful, it is almost essential that the operation be performed before congestion of the lungs has set in.

The trachea should be opened in preference to the larynx, in consequence of its greater distance from the seat of the disease, as well as for the reason that the disease may be extending low down in the larynx, and therefore exist at the very point usually selected for laryngotomy. Having thus by tracheotomy saved the life of the patient, scarification of the œdematous structures may be pursued more deliberately. This will be especially necessary if the tumefaction interferes with deglutition. Under circumstances of great urgency there ought to be no hesitation in opening the trachea with a pocket-knife, if no surgical instrument is at hand, and without any dissection, the delay for which may result in the loss of the patient.

Rupturing the bladder-like swelling by a smart stroke of the finger at the moment of examination has been recommended by Prof. Stromeyer. The epiglottis, when involved, may be firmly pressed against the root of the tongue, and would be very apt to suffer rupture of its attenuated mucous membrane under a vigorous stroke of the finger.

Where scarification or pressure fails to give immediate relief, tracheotomy should be resorted to

* *Lancet*, April 21, 1860.

at once, for the disease threatens death by suffocation before any impression can be made by ordinary antiphlogistic remedies; although there are a number of cases on record that have recovered under antiphlogistic measures. Catheterization of the larynx, which has been proposed for the purpose of promoting absorption, generally fails in affording any relief. Trousseau* has recorded a severe case of œdema of the larynx which was promptly relieved by inhalations of tannin; narcotic inhalations sometimes have a very happy effect. But treatment by inhalations is very rarely applicable, and not at all so where the symptoms are urgent. In one of the cases referred to, it was not employed with the hope of a favorable result, but as a means of temporary alleviation while in quest of a scarifying instrument.

In cases of but moderate severity, where the progress of the morbid process can be continually watched by the aid of the laryngoscope, the application of ice externally, and the continuous use of ice in the mouth, will sometimes effect an absorption of the effusion, and thus avoid any necessity for the use of the knife.

The œdema which occurs during the progress of chronic laryngeal disease usually sets in gradually, rarely insidiously, and may continue for a long period without producing any suffocative paroxysms, even when the entrance into the larynx is very much narrowed by the tumefaction. It seems as if the system accustomed itself to a gradual narrowing of the air-passages on the one hand, while on the other the general ill health of the patient and the lack of active exercise appear to lessen the demand for a large supply of oxygen. Certain it is that an amount of œdema is tolerated in chronic affections of the larynx which would cause symptoms of suffocation if it occurred suddenly in a healthy subject.

The œdema is more apt to be confined to one side than in the acute variety, probably because the laryngeal affection which produces it is often one-sided. Sometimes the condition is due to disease of the laryngeal cartilages, which have undergone caries or necrosis. The cricoid cartilage and the arytænoids are the most prone to become diseased in this manner; but the other cartilages do not possess any immunity from destruction. Ryland† mentions a case in which this was consequent on an attack of glanders contracted nearly a year previously; and in which dissection after death showed that the inner layer of the cricoid cartilage had undergone ossification, had become carious, and was partially loosened. Sometimes the detached and dead portions of cartilage are expectorated in coughing, and occasionally the sequestrum has been seen by means of the laryngoscope and then removed with forceps; and if any difficulty in detachment presents itself, tracheotomy may be necessary to remove the obstruction.

Scarifications, followed by the topical application of astringent solutions, such as solutions of nitrate of silver, sulphate of copper, chloride of zinc, chloride of gold, etc., with emollient and narcotic inhalations, constitute perhaps the best treatment. Blisters and other counter-irritants rarely do good, and are often productive of injury.

Opening the trachea for the mere purpose of setting the larynx at rest in chronic affections, as formerly advised by some, is rarely justifiable; for the affection terminates in death, and the respite is hardly worth its cost; besides which, the trachea is often entirely free from disease, unless congestion is excepted, and the condition of the lungs is usually such as to be in itself productive of all the phenomena of dyspnœa and cough. Under such circumstances the operation can hardly do more than actually add to the existing evils already endangering the remnant of the patient's life.

SUB-GLOTTIC ŒDEMA OF THE LARYNX.

The opinion has long been held by pathologists that œdema of the larynx could not occur below the glottis, on account of the close adherence of the mucous membrane to the perichondrium of the cartilages below the vocal cords. On the sides of the cricoid cartilage, however, there is a certain amount of distinct areolar tissue, which is sometimes sufficiently relaxed to permit the accumulation of exudative products, these being lymph rather than serum; though serous infiltration undoubtedly occurs in certain instances. This effusion is not an extension of the œdematous infiltration already present above the glottis, and, though occasionally coexisting with œdema above the glottis, usually occurs independently of any analogous condition in the ordinary localities of œdema in the upper portion of the larynx.

Sub-glottic œdema is an exceedingly rare affection. It has been recognized as an independent affection only since the employment of the laryngoscope in medicine; and the use of this instrument affords the means of certainty of diagnosis. We are indebted to Dr. Gibb, of London, for prominently calling the attention of the profession to this subject, which he has discussed at some length in the second edition of his work "On the Throat and Windpipe."

This form of œdema is sometimes produced by acute laryngitis, and the laryngitis of erysipelas, but also occurs in the course of chronic laryngitis of phthisis and syphilis; resembling in these respects the ordinary forms of œdema of the larynx.

As this subject is one not generally understood, and as a knowledge of the existence of sub-glottic œdema would have a considerable influence upon the locality to be selected for performing the operation of tracheotomy, in case such a procedure should become necessary, it may not be amiss to call attention to the cases detailed by Dr. Gibb. Dr. Gibb has collected, in all, evidence of eighteen instances of this affection, most of the material having been found at hand in the London hospitals. He states that "it may be taken as a rule that swelling never extends farther than the first ring of the trachea."

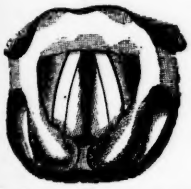
The subjective symptoms of the affection are similar to those of acute laryngitis, with those of

* Clin. Méd., Paris, 1861, p. 475. † On the Larynx, p. 42.

the ordinary forms of œdema; but the breathing is more stridulous and wheezing, and has a croupy hoarseness. There is great dyspnœa, cough, and an abundant secretion of mucus, rings of fibrinous sputa being sometimes expectorated. Symptoms of dysphagia are not manifested unless there be coexistent œdema of the upper part of the larynx, nor is there more marked stridor in inspiration than in expiration.

Laryngoscopic examination reveals projecting pads of mucous membrane bulging forward to the right and the left, below the vocal cords, and encroaching upon the transverse calibre of the larynx. (Fig. 9.)

Fig. 9.



Sub-Glottic Œdema of the Larynx.

Sub-glottic œdema is much more menacing to life than supra-glottic œdema; it is not so amenable to scarification and other topical treatment; not alone from the position of the effusion, which is below the glottis and therefore far more difficult to reach with instruments, but also because the effusion is not serous merely but fibrinous, and thus much less likely to be discharged through the incisions, even if the swelling could be scarified. The discharge of a serous effusion in the upper portion of the larynx, moreover, is assisted by the pressure exercised in the spasmodic contraction of the muscles, which follows the operation,—a result which there is no means of obtaining when the effusion is below the glottis and therefore out of the range of muscular compression. Tracheotomy is the only resource in severe cases. In cases of moderate extent and severity, the same remedial agents may be employed as in supra-glottic œdema; and from the fibrinous nature of the effusion we can reasonably expect a more salutary influence from the effect of mercurial remedies.

The deposit of sub-glottic œdema is not always absorbed, even if the patient should be saved by a timely tracheotomy; and hence it has been necessary in some cases to maintain the opening patulous by the constant presence of the tracheotomy-tube.

HEMORRHAGIC ŒDEMA OF THE LARYNX.

Hemorrhagic infiltration of the sub-mucous tissues of the larynx, to which the name of hemorrhagic œdema is frequently applied, is generally the result of some traumatic injury of the parts; giving rise to sudden and often fatal stenosis of the larynx. The hoarseness, dyspnœa, and dysphagia do not differ from those presented in the ordinary forms of œdema, but are dependent in great part on the locality and quantity of the blood effused. Sestier* relates a case in which the hemorrhagic effusion into the right ary-epiglottic fold followed upon a suicidal cut into the thyro-hyoid membrane, and caused a fatal termination by suffocation upon the fifth day after the injury.

Hemorrhagic œdema may also result from other than traumatic causes. Thus, Sestier† mentions the post-mortem appearances of hemorrhagic œdema in the ary-epiglottic folds, which occurred in the course of hemorrhagic smallpox. Rühle‡ gives a case of Pfeufer's. A man æt. 43, in freeing himself from vermin by inunction with mercurial ointment, became salivated. One evening, at six o'clock, he became chilly; and very soon after a severe cough set in, which soon acquired a croupy character. Dyspnœa set in, with stridulous respiration, and gradually increased, produced cyanosis, and suffocated the patient at eleven o'clock. Upon post-mortem examination a sub-mucous collection of blood was found in the larynx directly below the right ventricle, of the size of a quarter of an inch, and 1–3‴ thick in several places. The blood was liquid, and the mucous membrane over it was swollen. Pfeufer attributed the hemorrhage in part to the alteration of the blood produced by the mercury, and in part to acute catarrhal laryngitis.

* Traité de l'Angine laryngée œdémateuse, Paris, 1865, p. 137.

† Loc. cit., pp. 63, 114.

‡ Kehlkopfkrankheiten, 1861, p. 171.

ORIGINAL COMMUNICATIONS.

A CASE OF STRICTURE OF THE RECTUM PRODUCING OBSTRUCTION — DEATH ON THE SEVENTY-FOURTH DAY.

BY RICHARD MOFFETT, M.D.,
of Philadelphia.

W. H. S., aged 19, of slender frame, nervo-lymphatic temperament; by occupation a baker; had enjoyed average good health prior to his eighth year. At this time he suffered from an attack of dysentery, accompanied with prolapsus. The intestine had protruded to the extent of two inches. The subsidence of the disease developed a chronic torpor of the bowel, ending in constipation of a peculiar character: the stools were flattened.

After an immoderate indulgence in raw chestnuts and cabbage, the bowels became obstructed, November 15, 1871. The patient came under my charge November 20. At this time his tongue was clean and there was no febrile reaction. The abdomen was somewhat tumid, and the right iliac region was the seat of a dull aching pain. I at once ordered a two-ounce emulsion of castor oil with laudanum, and subsequently two drops of croton oil. These not producing the desired effect, they were followed by injections. These were equally fruitless. Upon the seventh day of the obstruction Dr. R. J. Levis was consulted. By his advice, tobacco-smoke enemata were given, but without any result. The rectum was explored, both by the finger and by bougies, but no obstruction was detected. The patient's appetite now became capricious; at times ravenous, it would disappear, and absolute anorexia persist for days together. The tongue now become coated, and the breath offensive. The treatment

from this time was chiefly supporting, it being deemed inexpedient to persevere in attempts to secure purgation. The abdomen growing more tense, and the pain increasing, it became necessary to resort to anodynes.

On the thirty-seventh day Dr. D. Hayes Agnew was consulted, who, with Dr. Levis, advised puncturing the abdominal wall to relieve the distention. This was done by means of a small trocar and canula, when a quantity of flatus escaped. The question of abdominal section now presented itself as a last resort to overcome the obstruction, which had been located by the consultants in the right iliac region. The fact that the obstruction had proven so obstinate without any vomiting of stercoraceous matter pointed, it was thought, to a cause situated within the large intestine, while the pain in the right iliac region indicated its position. After mature deliberation, it was decided not to operate; for were the obstruction detected at the head of the colon, it would in all probability be irremediable, even after free exposure of the parts. Upon the forty-second day, at the suggestion of Dr. Agnew, large quantities of sweet oil were injected daily. Small liquid motions, averaging half an ounce, followed each injection, and a larger quantity, in amount about the same as would ordinarily be voided at a stool, was removed about every third day. It was hoped that by this means a favorable termination of the case would be secured. But by the fiftieth day his skin, which up to this time had remained dry, was covered by a clammy secretion. The urine became scanty and high-colored, and the distention of the abdomen, which had become enormous, induced dyspnœa by the pressure upward against the diaphragm. The tongue remained thickly coated; the breath was exceedingly offensive; the pulse, which had remained throughout at the normal standard, rose to over 120, and at times was intermittent. It now became evident that he was sinking. He lingered until January 29, 1872, the seventy-fourth day, when he died of exhaustion.

Autopsy, January 31.—Present Drs. Moffett, Hunter, and Allen. Body much emaciated. The abdomen was enormously distended,—circumference thirty-six inches. The intercostal spaces of the false ribs were greatly widened: that at the sixth measured one and a half inches. The usual incision in the median line of the abdomen was made by Dr. Hunter, who conducted the examination. A large portion of the descending colon protruded through the opening. A casual examination of the abdominal cavity revealed little else than an enormously-distended colon. The sigmoid flexure was conspicuously elevated, and occupied the umbilical and hypogastric regions. It overlapped and tended to press inward the head of the colon. The splenic flexure was very acute. The circumference of the gut at this point was less than at any other. The hepatic flexure was discolored by the gall-bladder in the usual manner. The latter viscus was moderately distended with bile. The small intestine was distended its entire length. The stomach was pressed upward, but was not enlarged. The other viscera presented no features of interest. The colon upon being removed revealed a stricture completely surrounding the rectum as it lay directly below the right sacro-iliac junction. The diameter of the stricture was about four lines. Below it, the rectum was of the normal calibre; above, it presented the appearance characteristic of the healthy colon. The latter portion of the intestine was filled with fluid fæces of a dark loam color and of a fetid odor. Very little flatus was detected. The following were the measurements as recorded:

From pelvis to seventh rib, 15 inches.
From clavicle to seventh rib, 7½ inches.
Girth of abdomen, 36 inches.
Circumference of caput coli, 14½ inches.
Circumference of hepatic flexure, 12½ inches.
Spleen 4½ inches long, 2⅓ inches wide.
Kidneys 4½ inches long, 2 inches wide.

TRANSLATIONS.

VON OPPOLZER'S LECTURES ON DISEASES OF THE ŒSOPHAGUS.

Being the latter portion of the first part of the second volume of Oppolzer's Vorlesungen über specielle Pathologie und Therapie, Erlangen, 1872.

Condensed from the German of Dr. Emil Ritter von Stoffella,

BY DR. J. SOLIS COHEN.

(Concluded.)

VI.

CANCER OF THE ŒSOPHAGUS.

Cancer of the œsophagus is either fibrous, medullary, or epithelial. It is usually primitive, existing by itself; rarely consecutive, or the result of the encroachment of cancer of an adjacent organ.

Primitive cancer of the œsophagus involves, most frequently, the lower portion of the organ, in the vicinity of the cardia; but Von Oppolzer has observed it quite frequently in the thoracic portion of the œsophagus. It appears as a circumscribed disease, as a rule; occasionally, only, being extended over a great portion of the œsophagus, or even its entire length. It usually involves the whole circumference of the tube, and produces in this way an annular stricture; not infrequently, indeed, effecting complete occlusion of the calibre of the canal. Intimate inflammatory adhesions with the adjacent parts are formed within the reach of the cancerous degeneration, especially with the anterior surfaces of the vertebræ. Above the cancerous constriction the œsophagus is distended for a certain extent; below it, on the contrary, it is collapsed; a condition which occurs in all varieties of œsophageal constriction.

Cancerous disease of the œsophagus always begins in the sub-mucous connective tissue, whence it soon extends to the mucous membrane, upon which it becomes still further developed. The cancer softens, and uneven ulcers are formed, circumscribed by infiltrated borders, and covered with ichor from bleeding fungous vegetations. The diseased process extends to the neighboring organs; and the ulceration and destruction gradually acquire increased dimensions, so that communications may become established in this way with the lungs, the trachea, the bronchi, etc. At the same time, the cancerous formation may develop within the neighboring arteries, the aorta, and pulmonary artery, or

may produce erosion of the coats of these vessels by its destructive action, and thus give rise to fatal hemorrhage.

The most prominent *symptoms* of cancer of the œsophagus are those of œsophageal stenosis. Even before these symptoms attract special notice, the patient will exhibit a continuously progressive deficiency of nutrition and a loss of physical strength. He becomes emaciated, complains of debility and more or less loss of appetite, and finally acquires that appearance which is designated as cachectic. After several months or more have passed with these symptoms, difficulty in swallowing begins to be experienced, similar in the main to that observed in stenosis of the œsophagus from other causes, but increasing more rapidly to a severe degree. If the dysphagia has progressed so far as to have induced vomiting and regurgitation of ingesta, the food returned is at first mixed with stringy mucus, and at a later date with blood, ichor, and, now and then, with broken-off fragments of the cancerous formation.

There is not any pain, usually, in the earlier stages of the disease, or else the pain is very insignificant, and is confined to a slight burning sensation, or a feeling of pressure beneath the sternum, or at the pit of the stomach. Later in the case, however, and particularly after each meal, pain is felt, often of the severest lancinating character. Finally, in special cases, there are radiating pains in the upper extremities, particularly in the region of the shoulders and between the shoulder-blades, and also along the course of the intercostal spaces. If the cancer occupies the lowest portion of the œsophagus, near the cardia, painful paroxysms occur not infrequently, which can hardly be distinguished from those of cardialgia. Finally, in the later stages of the disease, when softening of the cancer and partial breaking-up have occurred, the calibre of the œsophagus will become greater, and the difficulty of deglutition will be diminished for a time.

The *prognosis* is unfavorable. There is no case on record which has not terminated fatally. The average duration of the disease has been found by Lebert to be about thirteen months. Von Oppolzer has remarked cases which have given rise to thrombosis, principally in the veins; or to secondary inflammation of the brain, or to gangrene of the lungs, thereby hastening the fatal termination.

The *diagnosis* depends chiefly on the advanced age of the patient, his cachectic expression, the slow progression of the malady, and the circumstance that it can in no other wise be accounted for. Complete and undoubted diagnosis can be made only upon the discharge of broken-up portions of cancerous matter by vomiting or regurgitation.

The *treatment* by dilating the œsophagus with sounds is advisable only in the earlier stages of the difficulty in deglutition. As soon as softening has commenced, such proceedings are dangerous, inasmuch as the softened tissues may be readily penetrated. In such cases the nourishment of the patient must depend upon so-called nutritive enemata; though they do not amount to much, because their subjection to chymification is wanting; besides which, they often induce inflammation of the mucous membrane of the large intestine. If the pain is severe, narcotics must be resorted to.

The reader is referred, in addition, to what has already been written in connection with cancerous stenosis of the œsophagus.

FIBROMA, AND FIBROUS POLYPUS OF THE ŒSOPHAGUS.

Fibroid nodules of the œsophagus occur but very rarely. They are mostly of but small size, in which case they produce no disturbances, and consequently cannot be diagnosed.

Fibrous polypus of the œsophagus is a more important affection than fibroma. Remarkable cases of this nature have been described by Rokitansky and by Munro. The fibrous polypus of the œsophagus usually arises from the perichondrium of the cricoid cartilage, and hangs down within the œsophagus. It gives rise to all the symptoms which attend constriction of the œsophagus, and, in addition, may occasion hemorrhage. If the polypus is situated in the uppermost portion of the œsophagus, it may be felt by the exploring finger, and even be made visible on retching. If it is large, it causes a projection in the neck.

The *treatment* of fibrous polypus of the œsophagus is altogether surgical.

NEUROSES OF THE ŒSOPHAGUS.

CRAMP OF THE ŒSOPHAGUS.

Cramp of the œsophagus—also called *spastic stricture of the œsophagus*—seldom or never occurs as an independent affection of the nervous plexus supplying the œsophagus; that is to say, as a true neurosis. It often occurs as a symptomatic spasm. Thus, we observe spasm of the œsophagus in diseases of the brain and spinal cord, in hysteria and hypochondria, in severe mental affections, and above all in hydrophobia, in which malady it is the most prominent symptom.

Reflex spasm, also, is no infrequent manifestation; to which category we may refer those cases of œsophageal spasm which attend diseases of the uterus, stomach (especially cancer of the stomach), heart, or lungs. In many cases the spasm is caused by disease of the œsophagus itself; as, for instance, in cases of inflammation, the formation of ulcers, etc.; and it often happens that cases of dysphagia, which are mistaken for simple spasm of the œsophagus, actually depend upon organic disease of the walls of this canal.

Symptoms.—The spasm may affect the œsophagus alone, or the pharynx likewise. It sets in suddenly, lasts a shorter or longer time, after which it disappears, to return at irregular, or, in rare instances, at regular intervals. In many cases the spasm occurs—especially when it is a symptom of hysteria—only upon the swallowing of solid or fluid substances, warm or cold; or it may be only certain kinds of food and drink that produce the spasm. The cramp is sometimes painless, sometimes painful, sometimes connected with a sensation as of a ball sticking in the throat (globus hystericus), or with a feeling of squeezing together, etc. If the upper portion of the œsophagus and the pharynx are affected with the spasm, then the food is rejected as soon as the attempt is made to swallow it. If the cramp affects the middle portion of the œsophagus, then either the further progress of the bolus is prevented, or regurgitation takes place, either immediately or after a while. Finally, in those cases in which the cramp takes place in the lowest portion of the œsophagus, in the neighborhood of the cardia, the patient can swallow, it is true, but the ingesta are very frequently regurgitated; and at the same moment the spasm suddenly relaxes.

If the spasm of the œsophagus is especially intense, or if it occurs in an irritable, so-called nervous individual, then it not infrequently happens that it extends to the respiratory organs and produces dyspnœa, anxiety as to the result, palpitation of the heart, and even, in some instances, loss of consciousness.

If an attempt is made to introduce a sound within the œsophagus during the spasm, the instrument will be arrested at the point of stricture, and be more or less firmly grasped by the walls of the œsophagus; but if we rest a moment, the instrument can be usually pushed onwards, without much effort, and suddenly, for the

most part, or with a jerk. Sometimes, in the anxiety of the patient, or in the dislike which he manifests at the catheterization of the œsophagus, the spasm will relax at the very moment that the sound is introduced, so that it can be pushed forward at once, without any hindrance, clear on into the stomach.

The duration of an œsophageal spasm varies very much; it may last a few minutes only, or may continue for several hours. It even happens, in many cases, that the spasm holds on, unbroken, for several days; and may thus, if such paroxysms recur frequently, interfere with the patient's nutrition to a very marked degree.

When the spasm relaxes, it is either simply by permitting the onward passage of the bolus detained in the canal, or by its forcible ejection; followed by the escape of flatus, and the secretion of a peculiar pale, straw-colored urine (urina spastica).

The *diagnosis* depends chiefly on the sudden appearance of the obstruction,—mostly during a meal,—the marked change from a greater or less degree of dysphagia to completely normal deglutition; the presence of other nervous symptoms, and of some disease known to give rise to spasmodic manifestations. Finally, catheterization of the passage gives the most valuable information towards establishing the diagnosis.

It is possible that it may alternate with a commencing stenosis, or with a paralysis of the œsophagus; but the manner of occurrence, the exploratory evidence of the sound, and the further observation of the patient will readily prevent the falling into error.

The *prognosis* will depend upon the cause which has given rise to the spasm.

Treatment during the Spasm.—As the patient cannot swallow during the spasm, medicine must be administered by the rectum, or by the skin. We order enemata of chamomile, valerian, assafœtida, camphor, etc.; sinapisms to the pit of the stomach and the neck; or the inunction of an ointment of cicuta, hyoscyamus, opium, or belladonna, along the spine. Above all, the subcutaneous injection of acetate of morphia or of atropia is to be especially recommended, both on account of its simplicity and feasibility, and on account of its usually prompt success. Besides this, warm tub-baths, eventually in connection with cold sponging, are to be recommended in cases where the cramp has continued for a long time. As a still further and, in many cases, a remarkably successful method of overcoming obstinate spasm of the œsophagus, the proceeding of Mondiére is to be extolled in cases of great sensibility of the œsophageal mucous membrane; this consists in the introduction of a sound smeared with belladonna ointment. If the spasm continues a long time, it will be necessary, in addition to the therapeutic measures, to institute measures for nourishing the patient artificially, by injecting the nutriment through a tube carried down into the stomach.

Treatment during the Interval.—When the spasm has ceased, we resort to the internal administration of zinc, valerian, belladonna, assafœtida, or some of the other so-called nervines. If the paroxysms of spasm are periodic, or if they return with frequency, we resort, in addition, to the influence of the sulphate of quinine.

If there is any special fundamental disease on which the spasm is dependent, it should always receive the fullest recognition in the selection of therapeutic agents.

PARALYSIS OF THE ŒSOPHAGUS.

Outside of traumatic causes, paralysis of the œsophagus is most frequently due to disease of the brain, spinal cord, and par vagum (tumors especially); chronic lead-poisoning, hysteria, diphtheritis, syphilis; or to severe febrile affections, especially typhus. Further, paralysis of the œsophagus is said to follow deglutition of hot drinks; exposure to cold; and fright.

Symptoms.—There are several grades of this affection, varying from a slight paresis to complete paralysis. At the commencement the patient merely remarks that the bolus will not progress properly; repeated acts of deglutition, or the swallowing of water after it, being necessary to force it farther. Large mouthfuls are swallowed better than small ones, and solids better than fluids; and swallowing is performed much better in the erect than in the recumbent posture. Fluids pass down into the stomach with one or more sonorous movements,—a symptom designated as "deglutitio sonora" by the older writers. The difficulty in swallowing gradually increases, and neither the size of the bolus, nor its consistence, nor even the position of the patient, seems to have any influence on the want of facility in swallowing; and finally complete dysphagia exists.

The latter condition is principally observed when, as is not seldom the case, the pharynx is paralyzed as well as the œsophagus. There is no pain during the entire course of œsophageal paralysis, and only occasionally does it happen that regurgitation occurs. If the parts are explored by the sound, no obstruction is perceived at any point, and the instrument can be moved about in all directions.

Paralysis of the œsophagus is not infrequently complicated by paralysis of the pharynx, as already mentioned, but it is also associated, in some instances, with paralysis of the arms, the face, the tongue, the soft palate, the larynx, etc. The combination of paralysis of the œsophagus with paralysis of the tongue and of the larynx places the patient in a very wretched condition, which has been thus strikingly described by Hamburger: "When paralysis of the muscles of the tongue and of the larynx is associated with paralysis of the pharynx, there is always a paralysis of the respiratory muscles, rendering the last days of the patient's life the most torturing that can well be witnessed. At each attempt at deglutition, which must often be made on account of the great thirst or hunger, a portion of the matters pass into the larynx, without the power on the part of the patient to expel them promptly, on account of the great debility of the respiration. What martyrdom, for hours, to free the larynx once more! and hardly is this accomplished when the torture begins again, as every particle of saliva which should have been swallowed passes into the larynx. The last days of the patient present a spectacle of unspeakable distress. Bowed forward, with the saliva flowing unrestrainedly from his mouth, he sits fretted with constant coughing and hawking, debilitated by hunger and thirst, to utter inanition, until, finally, the heart unexpectedly stops of a sudden."

The *auscultatory evidences* of paralysis of the œsophagus are analogous to those of dilatation. It is, therefore, unnecessary to recapitulate them.

The *prognosis* is, in general, unfavorable; especially when the paralysis is not restricted to the œsophagus.

The *treatment* is to be directed against the original cause of the malady. If this treatment is unsuccessful, or if the cause cannot be determined, resort is made to electricity, to blisters or irritating ointments along the spine, to irritation of the œsophagus itself by the frequent introduction of the sound, to cold sponging in combination with frequent douching, and to the internal administration of strychnine, or its hypodermic injection when the former fails.

The nourishment of the patient must be conducted by means of the stomach-tube, if the paralysis is very great. If the patient is still able to swallow, mouthfuls that stick in the œsophagus during meals—as is so often the case—must be pushed down with the œsophageal probang.

PHILADELPHIA
MEDICAL TIMES.
A WEEKLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

All communications must bear the name of the sender (whether the name is to be published or not), and should be addressed to Editor Philadelphia Medical Times, care of the Publishers.

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SATURDAY, MARCH 15, 1873.

EDITORIAL.

"BOGUS" DIPLOMAS.

ACCORDING to the published reports of the Pennsylvania Legislature, on March 4, 1873, in the House of Representatives,

"Mr. Josephs offered the following:

"*Whereas*, A Joint Committee of the Legislature in 1872, in accordance with instructions, made a report upon the sale of bogus diplomas in Arts and Medicine, and, in accordance with said report, the charter of the Philadelphia University of Medicine and Surgery was repealed, with the view of arresting the said sale and traffic in such degrees; and

"*Whereas*, It is believed that the traffic is still carried on, even to a greater extent than before, and that the Eclectic College and American University of Pennsylvania [Philadelphia], whose charters were repealed, are still in operation; and

"*Whereas*, The following advertisement is circulating in Europe:

"'Extracts from the Statutes of the University of Pennsylvania, of Honorary Degrees in Divinity, Law, Arts, and Medicine.

"'First. These may be conferred either at the instance of the Faculty, or in pursuance of a resolution of the Board of Trustees, but no such degree shall be conferred unless the mandamus ordering the same be signed by two-thirds of the whole number of trustees, nor unless the candidate shall have been nominated at the Board three months previous to taking the question on conferring the degree.

"'Second. The question of conferring an honorary degree shall always be decided by ballot, and the candidate must receive an unanimous vote.' And

"*Whereas*, The Mayor of Philadelphia has recently called the attention of the public to the fact that he has received from Europe information that bogus degrees are still a matter of merchandise, emanating from Philadelphia: therefore,

"*Resolved*, That a committee of five members of the House be appointed to investigate the Eclectic Medical College, the Homœopathic Medical College, the Jefferson Medical College, and the Pennsylvania University, together with all other colleges acting under the authority of the State, with power to send for persons, papers, and books, and who shall act without compensation.

"This resolution was urged by Mr. Josephs, who said that City Solicitor Collis had ascertained in Europe that the bogus diplomas were still issued.

"Mr. Mahon opposed the resolution, as being too broad, and as, in a measure, recognizing the existence of colleges whose charters had been repealed.

"The resolution was defeated by 32 yeas to 55 nays.

"Mr. Josephs offered a resolution instructing the Attorney-General to inquire whether the colleges whose charters were repealed in 1872 were still issuing diplomas.

"Mr. Josephs sent to the clerk a number of extracts from newspapers, showing that diplomas were still sold.

"Mr. Elliot (Speaker) held that the Legislature owed it to the people to protect them against quackery, and he could not see why any one should oppose the examination.

"Mr. Hancock said that the Legislature had repealed the charters, and could do no more.

"Mr. Elliot said that the law authorized damages to be found against railroads for killing people at the rate of $5000 per man. How many men would the quacks kill when armed with bogus diplomas?

"Mr. Hancock opposed investigating committees in general, and denounced the law which had limited railroad damages to $5000, as an outrage. He was really in favor, however, of the last resolution, instructing the Attorney-General to inquire into the matter.

"A running debate took place as to the best way of reaching the desired end, viz., the punishment of those who issue bogus diplomas.

"The following was finally passed:

"*Resolved*, That the Attorney-General be instructed to inquire whether any person or persons purporting to be officers of legally authorized medical colleges are issuing diplomas purporting to have the official seal of colleges whose charters have been repealed."

In connection with this subject, the following letters have been placed at our disposal, and we present them in their original language, with a translation, for the information of our readers:

No. 1.

MR. P. F. A. VAN DER VYVER,
DOCTEUR EN DROIT, JERSEY, ANGLETERRE.

24 Nov. 1872.

MONSIEUR,—En réponse à la lettre que vous venez d'écrire, j'ai l'honneur de vous informer que j'ai en mon pouvoir les moyens de vous faciliter l'obtention du diplôme que vous pouvez désirer de l'Université américaine de Philadelphie, dont je vous remets les statuts ci-inclus.

J'entreprends toutes les formalités à mes frais, risques et périls; ainsi vous obtiendrez votre diplôme sans vous déplacer.

La totalité des frais s'élève à six cents francs sans avoir autre déboursé à faire.

Je suis à votre service pour tout ce que pourra vous être utile et agréable, et vous prie d'agréer mes civilités empressées.

P. F. A. VAN DER VYVER,
46 Rue du Roi,
Jersey (Angleterre).

No. 2.

MR. P. F. A. VAN DER VYVER,
DOCTEUR EN DROIT, JERSEY, ANGLETERRE.

29 Nov. 1872.

MONSIEUR,—Je pourrais procurer à votre protégé ce qu'il a besoin et même plus, car je pourrais lui influencer les deux titres de Docteur de Philosophie et Bachelier-en-Lettres sur le même diplôme pour un seul honoraire de six cents francs y compris le certificat d'inscription.

Il y aurait aucun déplacement pour votre protégé à faire; vous auriez seulement à me satisfaire par votre correspondance, que le candidat possède les qualifications, et alors j'enverrai sa promotion au délégué de l'Université américaine à Philadelphie, et il est certain qu'il obtienne son diplôme.

Plusieurs personnes éminentes de Bruxelles et des départements ont déjà obtenu leur diplôme par mon entremise.

Recevez mes civilités empressées.

P. F. A. VAN DER VYVER.

Réponse au plutôt S. V. P. pour que la nomination se fasse vers la fin du mois de Décembre, quand la session actuelle termine et les examens auront lieu.

No. 3.

MR. P. F. A. VAN DER VYVER,
DOCTEUR EN DROIT, JERSEY, ANGLETERRE.

12 Déc. 1872.

MONSIEUR,—Il est surprenant que votre ami vous a tellement renseigné.

Il existe grand nombre de bonnes Universités dans les États-Unis, et notamment à Cambridge, Providence, New Haven, Philadelphie, Columbie, etc.

Il y a à Philadelphie 3 ou 4 bonnes Universités, dont l'Université de Pennsylvanie établie en 1755 occupe le premier rang, et l'Université américaine établie en 1840 occupe le deuxième en [*sic*] rang.

Du reste, vous trouvez dans l'almanach des adresses de Philadelphie, notre Université. Les diplômes, qui sont en latin, porte que l'Université possède le plein pouvoir d'accorder des diplômes.

Du reste, l'Université est établie depuis 40 ans; ainsi votre ami doit peu connaître la ville de Philadelphie pour ne pas se rappeler de cette Université.

Recevez l'assurance de mes bons sentiments.

P. F. A. VAN DER VYVER.

TRANSLATION.

No. 1.

MR. P. F. A. VAN DER VYVER,

DOCTOR OF LAWS, JERSEY, ENGLAND.

November 24, 1872.

SIR,—I have the honor to inform you, in answer to your late letter, that it is in my power to assist you in obtaining such diploma as you may desire from the American University of Philadelphia, a copy of whose regulations I enclose.

I will fulfil all the formalities at my own expense and risk, so that you will obtain your diploma without leaving home. The expenses will amount to six hundred francs, including everything.

I offer you my services for whatever may be useful or agreeable to you, and beg you to accept my sincere compliments.

P. F. A. VAN DER VYVER,
46 Rue du Roi,
Jersey (England).

No. 2.

November 29, 1872.

SIR,—I am able to procure for your friend all that he desires, and more besides, for I could obtain for him the two titles of Doctor of Philosophy and Bachelor of Arts upon the same diploma for the single fee of six hundred francs, including the expenses.

Your friend need not leave home; you will only have to assure me by letter that your candidate is properly qualified, and then I will forward his nomination to the agent of the American University of Philadelphia, and it is certain that he will obtain his diploma.

Several eminent persons in Brussels and in the departments have already received diplomas through my intervention.

Accept my sincere respects.

P. F. A. VAN DER VYVER.

Please to reply as soon as possible, so that the nomination may be made before the end of December, when the present session ends and the examinations will take place.

No. 3.

December 12, 1872.

SIR,—It is surprising that your friend should have given you such information.

There is a large number of good Universities in the United States, particularly at Cambridge, Providence, New Haven, Philadelphia, Columbia, etc.

At Philadelphia there are three or four good Universities, among which the University of Pennsylvania, founded in 1755, holds the first place, while the second in rank is the American University, established in 1840.

Moreover, you will find our University in the Philadelphia Directory.

The diplomas, which are in Latin, state that the University has full authority to confer diplomas.

Besides, the University has been established for forty years: so that your friend must have but little knowledge of the city of Philadelphia if he does not remember this University.

Accept the assurance of my friendly feelings.

P. F. A. VAN DER VYVER.

It will be inferred from one of these precious epistles, that of December 12, 1872, that Mr. Van der Vyver's correspondent must, on information received from a friend, have suggested some doubts of the genuineness of the "American University of Philadelphia." The accommodating gentleman thereupon expresses his surprise at such incredulity, and, in order to clinch the proof of his own veracity, transmits a photograph of the "University," and requests the correspondent "to ask his friend if he does not remember Pine Street, and the large building represented in the photograph." This "photograph" turns out to be the photograph not of the college itself, but of a wood-cut bearing the printed title "The American University of Philadelphia, 514 Pine Street, Philadelphia, U.S.A." It represents a double three-storied building with a French attic, with a large door in the centre, and in the second and third stories large triple windows above the door. Surmounting the roof is an ornamental balustrade; and from a lofty flag-staff the American flag waves over all.

Having no recollection of such an edifice in the locality, with which, however, we were pretty familiar, we made a pilgrimage to this Mecca of diploma-desiring aspirants; and, behold! no building even remotely suggesting the print was to be found. Two very old and plain three-storied brick dwelling-houses, each of them about twenty-two feet front, were the only representatives of the "grand bâtiment" of the honorable Mr. Van der Vyver. One of them is occupied by a manufacturer, not of "doctors," but of cabinet furniture; and over the door of the adjoining one, in brazen letters, is the inscription "Eclectic Medical College of Philadelphia;" and all around are tin signs setting forth what diseases are to be cured within. The "grand bâtiment" is simply a myth!—whether devised by the honorable Doctor of Laws of the island of Jersey, or by some of those astute natives who seem to care very little for the law, the legislature, or the attorney-general, is not certain. But it is high time that the power should not only be found, but should also be vigorously used, to crush out this brood of rogues, who seem to laugh at law, while they are dragging in the kennel the names of honest institutions and everything which honest men respect.

AN EXCELLENT MEASURE.

EVERY good citizen of the United States, and in fact every friend of purity and good morals everywhere, will hear with pleasure that a bill "to prevent the mailing of obscene books, papers, articles, and advertisements"—we quote from one of the daily papers—has passed both Houses of Congress and received the President's signature. Faithfully executed, such a law will be an incalculable benefit to the nation.

The nefarious business of scattering obscene publications is, if we are rightly informed, one which can be, or has been, carried on to advantage only through

the mails; since, for obvious reasons, there must be no direct contact between the actual producer and the buyer. We have had brought to our notice, from time to time within the last twenty years, a very large number of advertisements of vile books and pictures, not for sale at any given place, but to be had by sending the price to specified addresses. This practice can be attacked only by the general government, which alone can control the mails. It remains for each State to enact and execute such laws as shall protect its citizens from more direct and open offences against social morality.

It is perhaps hardly necessary to point out the bearing of such legislation, duly enforced, upon the public health. The evil effects of obscene books and papers in fostering the lowest passions, in promoting solitary vice, in debauching the pure, and in rendering the impure worse, can scarcely be over-estimated. By checking the publication of this vile rubbish, one of the great sources of immorality, of the physical and moral ruin of the young, and of venereal disease, insanity, and pauperism, would be cut off.

LEADING ARTICLES.

RECENT IOWA LEGISLATION CONCERNING INSANE HOSPITALS.

II.

IN the last number of the *Medical Times* we adverted to the distrust and suspicion apt to attach, in the public mind, to persons who have occasion to confine insane relatives, to physicians who recommend the step, and especially to all hospitals for the care of this unfortunate class. As one of the latest and most outrageous manifestations of this unjust and bitter spirit, we gave the substance of an act lately passed by the General Assembly of Iowa. We now propose to show the alarming and most mischievous tendency of the act, and to glance at the influences by which legislators were led so singularly to commit themselves.

No one will deny that one proper object of an insane hospital is to exert a certain control and government over persons who have either lost the power of self-control, or have ceased, in consequence of disease, properly to exercise it. In many cases of insanity—even in most—control is imperatively demanded, for the safety of the patient, of his friends, and of his property, and for the peace and order of society. Such restraint, of course, abrogates for the time personal liberty. This is unavoidable; and the only question is, how this coercion can be exercised with the greatest comfort and security to patient, family, and society, and with the best prospect of ending its need by cure. At home, any attempt to govern is fiercely opposed or peevishly complained of. Accusations of ingratitude, loss of natural affection, oppression, or cruelty, are freely made. Reproaches, added to the already distressing grief, sympathy, and agitation of the friends, cause their measures of control to be fitful, injudicious, and irritating. Tears, upbraidings, entreaties, fierce denunciations, and excited appeals, met by equally passionate avowals of sympathy, and by useless reiterations of argumentative attempts to make the insane man feel and think as if he were sane,—these things make the lives of most insane persons at home, if not utterly demented, scenes of perpetual wrangling and contention, leading almost surely to chronic, life-long derangement. The sane relatives are certain to suffer terribly in mind and body from the ever-present sorrow, the strife, and the sleeplessness.

On the other hand, let the same patient be placed, without deception, in a hospital early in the disease. He may resist, use violent and bitter words, and breathe vengeance on all concerned. Still, he is there, and the door is closed. He sees others around him conforming their lives to rule and system. He is treated courteously and kindly by officers and attendants. He perceives that they consider him, not as a prisoner to be punished, but as a sick man to be cured. They have no connection with his home-troubles, and hence provoke no bitter feelings. If at first, or at times, he be violent and abusive, he is met only with a few kind, firm words, or gentle but efficient restraint. He is indulged in no heated discussion. If he write angry letters to his family, he receives no answer; and the fires of his wrath die for want of fuel. If not furiously maniacal, he recognizes the power of his physician as absolute and inevitable. The hospital is a ship, and the superintendent its captain, whose supremacy is unquestioned. The patient thinks it all wrong for him to be there; he is not insane; he would have got along perfectly well at home if they had only let him alone; he was only a little nervous, or harassed by business, or angered by the disobedience or interference of wife or child. Still, in point of fact he is calm and tranquil, as compared to his state at home. The mental splints are upon the broken mind, and the conditions favor cure. Later, he perhaps admits his recent insanity, but claims that he is now well, and that he should be discharged. In vain would be the warning that his brain is still perilously weak and irritable.

But for the power to hold him against his will, he would prematurely plunge into the busy world, with all its excitements, and the additional trying ordeal of meeting friends and acquaintances after so painful and, to him, humiliating a separation. As it is, if spared interference from without, the wise physician detains his patient a few weeks longer. When at last discharged, he is usually grateful, though perhaps deeming the doctor over-cautious.

Let us now observe what havoc this infamous law would make in a case like that just described,—a true picture of many witnessed by the writer. Glancing about the hospital ward, he sees posted the addresses of persons whose business it is to receive complaints. He learns that the superintendent is compelled to forward his letters. He perceives at once, or as soon as his brain begins to clear, that the officers are treated as if known to be dishonorable, corrupt, abusive, and untrustworthy. He knows that any tale of outrage—which the moral obliquity so often characterizing the insane may lead him to invent for mischief or in hope of release—must pass to this committee unseen by the physician. He is visited monthly or oftener by the committee, for the purpose of discovering whether he is abused, or wrongfully committed, or unduly detained. Of course, any man chafing under confinement is likely to find or invent some matter of complaint, when so urgently invited.

This committee, appointed under the influence of such a degree of popular distrust as alone could prompt such legislation, will be certain to represent and share the public prejudice. If one member, only, share this feeling, whatever raw-head-and-bloody-bones stories reach him—and many will—are sure to become public, to the infinite distress of all who have relatives in the hospital. For he is bound under heavy penalties to investigate all matters, and would not desire, even were he able, to preserve secrecy.

Among the results of this act, then, we find the destruction of the patient's confidence and of the physician's good influence and authority. The curative power of the hospital is ended. Even were it not wholly destroyed, the convalescent would be discharged half cured, by, or from fear of, the committee. The superintendent cannot attempt to enforce discipline on sane or insane, lest he be complained of and slandered.

Constant publication of tales of atrocities will lead to the removal of old cases, and prevent the sending of acute cases so long as they can possibly be retained at home. When at last intolerable in the family, they will have become incurable anywhere. The terrible distress of relatives hearing these stories, we have before mentioned.

Good attendants will refuse to remain, in peril of criminal conviction by the inventions or delusions of the insane. A lower class, reckless and unfaithful, with nothing to lose, will succeed them. Discipline, order, and tranquillity will be banished from the wards.

Worthy, efficient, and experienced men will not long consent to act as physicians in State hospitals where this law shall be placed and retained on the statute-book. Unprincipled adventurers, or at best men wholly ignorant of their duties, will succeed the educated and honorable superintendents.

In short, total demoralization must ensue in all departments of a hospital long managed under this law.

Testimony from the superintendent of the Iowa hospital, only a month after the passage of the act, shows evil effect on patients, resignation of "eight of my most experienced and valuable attendants," premature removal of four curable patients, due to deceptive letters sent out, as the first fruits of this "tree of bitterness."

To one acquainted with the history of the Iowa State hospital, the passage, in that State, of such an act seemed almost incredible. Dr. Ranney has been at the head of the hospital some seven years. He has enjoyed, to a degree unusual in State hospitals, the confidence of trustees and the legislature. His remarkable success, both as a medical and an administrative officer, including the planning and executing of important improvements, caused his representations to be treated with much respect. His friends were proud of the consideration with which his views were listened to, and the liberality with which appropriations were granted by the legislature. It is not alleged that he has done anything to forfeit this respect and confidence. Yet the General Assembly passed this act with only two or three dissenting voices,—all in the upper house! The lever exerting such energy was systematic, industrious misrepresentation; the fulcrum, popular credulity; and the power, a woman's tongue!

This woman was insane a number of years ago, and was for several months a patient in a New England hospital before her marriage. She was discharged as recovered. Twenty years later she was an inmate of the Illinois State hospital, for, we believe, two or three years. She was discharged against her will, and removed by force, as incurable, to make room for more hopeful cases, some nine years ago. She professed to suffer and to witness great abuses in the hospital, and succeeded in bring-

ing about a legislative investigation. This occupied a long time, received the testimony of many witnesses, sane and insane, did great injury to the usefulness of the hospital, and led to the resignation of its superintendent. For some reason the lady retained a bitter spite against insane hospitals, and has begun a crusade against the entire class. She is very shrewd and plausible, gaining full belief not only from those whose faith covets the impossible for its exercise, but also, in many instances, from persons of culture and intelligence. In regard to this Iowa law, we learn that she devoted herself to the task of interviewing every member of the legislature, assuring them of the existence of abuses in their own hospital, and urging the passage of this bill, which is said to be of her own concoction. Her marvellous success is shown by the unanimity with which the monstrosity was passed. Surely woman needs not the ballot, when without it she can wield, for evil the power of this lady, and for good, that of Miss D. L. Dix.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY, JANUARY 23, 1873.

THE PRESIDENT, DR. J. H. HUTCHINSON, in the chair.

DR. CHARLES H. THOMAS presented the following specimens:

1. *Ulceration of the colon, with a much enlarged fatty liver*, removed from a man aged 40, apparently previously healthy, who sent for him November 10, 1872, suffering from what he described as a troublesome "diarrhœa." There was no fever, and little or no abdominal pain, but some tenesmus, for which an opium suppository was ordered. Two days later, though no worse in respect to the discharges, which were now slightly bloody and mucous, he became much depressed in spirits, complaining of nausea and a distressing thirst. He had a weak, compressible pulse. From this time to his death, which occurred on the ninth day after the attack, he gradually failed in strength, seeming to die of inanition rather than of active disease.

Post-mortem examination, aided by a student, Mr. Theron Wales, revealed but a slight amount of the inflammation characteristic of dysentery in the rectum, colon, and lower portion of the ileum, as the specimens show. But nothing in the condition of the intestinal tract indicated sufficient disease to cause death. The liver, however, was enlarged to twice its normal size, much softened, and in an advanced stage of fatty degeneration. The case appeared to Dr. Thomas clearly one of mild *dysentery*, superposed upon the grave liver-affection, to which—though previously unsuspected—the fatal termination was chiefly due. The doctor afterwards learned that the patient had for years thought his liver diseased, and that morning-nausea of the most distressing character had long disturbed him. His attendance and observation of the case were seriously embarrassed by a lapse of three days after the fifth day,—during which time a "homœopath" made ineffectual trial of his potencies. When called upon to resume charge, the patient was already moribund.

2. *Encephaloid tumors of leg and liver*, removed from Mrs. ——, æt. 45, who attended as an out-door patient at the surgical clinic of the Woman's Hospital during his service there, in August, 1872, to seek relief from a bleeding encephaloid tumor, about two inches in diameter at its base, situated upon the calf of the left leg, and of six months' standing. Under applications of chromic acid, in substance, to the morbid mass, it sloughed off in about three weeks. The succeeding ulcer refused to heal completely.

Early in November the patient again consulted him in regard to a small growth at the site of the ulcer, like the one removed, which gave her some uneasiness of mind; and, further, to obtain ease from "a terrible pain at the pit of the stomach," and, to his surprise, —considering her age and her very decrepit and cachectic appearance,—to engage attendance in her approaching confinement, which was to take place three months later. This was her *seventeenth* pregnancy,—nine of her children being now alive.

By palpation, a large mass was felt in the right hypochondrium, which was exquisitely tender upon pressure. The area of percussion-dulness also was enlarged. The pain in the part had been severe and almost constant for *two years*. Nausea, which nothing allayed, except for a short time, was a source of much annoyance and consequent exhaustion. A combination of morph. sulph. and potass. bromid. in full doses gave her considerable relief from pain.

At this time cancer—of the liver primarily, of the leg secondarily—was diagnosticated. After a month she became decidedly worse, with augmented epigastric pain and irritability of the stomach, accompanied with much emaciation and almost total sleeplessness. Early on the morning of December 24, the doctor was called to her bedside, and was informed that during the night her right foot "had mortified, and that she was in agony from it." On inspection, this proved true; the sphacelation extending, within the succeeding four hours, as high as the knee. At this time her mental faculties were unimpaired, while her complaints of the pain in the foot and region of the liver were pitiful to hear. No signs of the beginning of labor were to be seen,—the pain being singularly unremitting, and always distinctly localized as above stated. But, as she was now evidently sinking rapidly, the probable near approach of death was announced to her friends, when he was told by an attendant that "something was passing from her." It was then discovered that a dead and decomposing fœtus, of the eighth month, was partially extruded from the vagina. This was removed, and an examination made, which showed that, with the placenta still within the uterus, and the latter contracted with moderate firmness, no hemorrhage was occurring; and, as she was undoubtedly *in articulo mortis*, she was not further disturbed. At this juncture Dr. Lewis D. Harlow saw her; no further action was considered advisable, and the patient died in about two hours afterwards.

Autopsy, Mr. Theron Wales assisting.—1. The accompanying growth was removed from the leg. 2. The abdominal viscera were found free from disease, excepting the liver, which weighed about ten pounds, and was studded with a profusion of encephaloid nodules like the specimen presented, and partially disorganized. 3. The uterus was found completely contracted; the placenta lying loose in the vagina; the walls of the uterus being nearly two inches in thickness, anteroposteriorly.

The specimen was referred to the Committee on Morbid Growths, who reported that the *primary* growth exhibited by Dr. C. H. Thomas was a *medullary carci-*

noma with well-marked alveolar arrangement of epithelial-like cells. The secondary growths were not examined, on account of their defective preservation.

Dr. THOMAS also called attention to what he deemed a most convenient means of transporting specimens from the place of post-mortem examination or under any circumstances where it was desirable to avoid attracting attention. This article was the simple *toilet sponge-bag* for travellers, sold by most apothecaries. This is impervious to liquids and odors; and by means of it he was able to bring specimens this evening which he could not otherwise have obtained.

Syphilitic Panaris in an Infant.—Dr. JOHN ASHHURST, Jr., mentioned that among the out-patients attending at the Children's Hospital was a child, only twenty months of age, which presented a marked example of the affection known as syphilitic panaris, or, as it is now called, dactylitis syphilitica. The patient was unquestionably a victim of hereditary syphilis, and the lesion of the finger had begun to manifest itself five months before the child was brought to the hospital,—at the early age, therefore, of fifteen months. While Dr. Ashhurst thought that syphilitic panaris was hardly so rare a lesion as it has been considered by Dr. Taylor, of New York, he looked upon its occurrence at the age of the patient whose case he was describing as somewhat exceptional.

REVIEWS AND BOOK NOTICES.

DISEASES OF THE OVARIES: THEIR DIAGNOSIS AND TREATMENT. By T. SPENCER WELLS. Pp. 478. New York, D. Appleton & Co., 1873.

Like the fire of the prytaneum, the lamp of knowledge never goes out; some hierophant stands ever ready to feed the sacred flame. Within a few short weeks, twice has this been done in a single department of science, and that by our own countrymen. This time it is by a citizen of no mean city, himself the *pontifex maximus*.

Above its fellows will the book before us be welcomed, not only by specialists, but by all those members of the profession who strive to keep abreast of the times. An author who has had an experience in ovariotomy larger than any other that ever has been or ever will be,—an experience of five hundred completed operations, twenty-eight uncompleted ones, and twenty-four cases of exploratory incisions; an experience whose record alone needs the respectable library of over thirty portly blank-books,—such an author is entitled to take rank over all others in his chosen branch of the profession. Yet the most renowned operator is not always the best teacher, and this book has somewhat disappointed us. Narrowed down to the record of one man's work, it has the "backbone of individuality," but not the scope of a complete treatise. In that sense it cannot for a moment compare with the peerless monument of industry that Dr. Peaslee has given us.

The first 116 pages describe the histology and regional anatomy of the female reproductive organs, together with the pathology of the ovaries. The diagnosis of ovarian tumors takes up the next 141 pages. The remainder of the book discusses their treatment. An intimate acquaintance with foreign literature,—so rare in an Englishman,—a sure-footed and far-sighted judgment, a conscientious industry, and the unrivalled affluence of his experience, render this treatise a noble store-house of knowledge. Yet it is not wholly invulnerable: it was the heel of the great Achilles that missed the baptism of the Styx; it is mainly the manner, and not the matter, that challenges our criticism.

To the microscopic characteristics of the ovarian fluid the author attaches but little importance. For all practical purposes, indeed, his "conclusions from micro-chemical examinations" are very impotent conclusions. Despite the alleged discovery by Waldeyer of a special epithelial tunic, he gives the ovary the usual peritoneal investment. This he contends is, after the age of thirty, the normal anatomy of that organ. In the very young, something like a germinal epithelium may be seen; but confirmatory investigations by other histologists must be made before views can be accepted which "would materially affect some physiological doctrines." He maintains that "from the sixth to the ninth month, most clearly about the eighth, the fœtus may be made to ballot upon the finger in the vagina." Now, apart from our very decided objection to the introduction of the "ballot" into obstetrics, we take exception to this teaching. The best writers upon obstetrics make the range of ballottement lie, as a rule, between the end of the third and the beginning of the seventh month; and this our own experience confirms. Were this not so, there would be no trustworthy method of diagnosticating the condition of pregnancy earlier than that by auscultation.

In the matter of anæsthetics, Mr. Wells uses the bichloride of methyl, because it contains one equivalent less of chlorine than chloroform, and is not so liable to be followed by vomiting. He gives it in the form of a spray.

Through a strange oversight, he makes no mention of Dr. Miner's treatment of the pedicle by enucleation. Of the extra-peritoneal method, however, there exists no warmer partisan. Of course the thorny question of *post aut propter hoc* at once comes up; but, after so rare a success with the clamp as a mortality of only 25.4 per cent., he could not speak otherwise. In advocating its use he offers the following excellent reasons. Owing to the very uniform presence of the Fallopian tube in the stump, in one-third of those cases in which the pedicle is treated outside of the body, the wound, for some time after the operation, reopens at every month to permit the escape of menstrual fluid. Such being the case, it stands to reason that the same phenomenon must as well take place in a stump returned into the cavity of the abdomen, exposing the woman, therefore, to all the dangers arising from hæmatocele. Then, again, whenever the pedicle is treated by the intra-peritoneal method, the raw surface of the stump becomes sealed by contracting adhesions with the intestines. A fatal occlusion of the bowel is thus liable to happen, or a collection of pus, becoming circumscribed, has ultimately to find an outlet by a long sinus.

The etiology of diseases depends almost exclusively upon statistical inquiries; but, very unfortunately, the author's have not been handled with that care which the importance of the subject demands. His facts have not been teased apart. His tables seem to have been constructed solely with a view to discover the elements of success and to authenticate his cases. Much more than this should have been aimed at. For instance, "the conjugal condition" of his five hundred patients is lamely exhibited by the bare statement that two hundred and seventy-nine were married, and two hundred and twenty-one unmarried. We are not told whether the unmarried were so *de jure* or *de facto*; what proportion of the married were widows; whether his married patients were, before the operation, sterile, fruitful, or fecund; and, in so many words, what was the average age of his patients. On these questions hinges much of importance in the elucidation of vital statistics. Verjuice and virginity, crabbedness and celibacy, are popularly deemed inseparables. Fibroid tumors, polypi and cancers, and a host of other uterine disorders, have hitherto been loosely attributed to a life of single bless-

edness. Very recently this has been made the subject of scientific inquiry. From a careful examination of the Registrar's tables, Bergeron has lately shown that marriage prolongs life in both sexes, by giving a comparative immunity from sexual diseases. This statement Mr. Wells's statistics will be found to confirm, provided the reader takes the trouble to do what the author should have done. By carefully going over these tables, we have counted up nineteen widows. Now, by deducting this number from that of the married, and by adding it to the sum of the unmarried, we obtain the enormous ratio of two hundred and forty women without husbands to two hundred and sixty with husbands. The significance of these figures can hardly be over-estimated; for it goes to show that unless the cycle of reproduction is completed in woman, she is plainly violating some great law of her being. With a population fully equal to that of the British Isles, we have in our own country certainly fewer cases of ovarian disease. May not this comparative immunity be owing to the fact that the disproportion of the sexes is less in the United States than in the mother-country?

It is gratifying to learn that the removal of one ovary does not unsex a woman. Of thirty-five of Mr. Wells's patients who got married after the operation, fourteen have since had one or more children; two have had twins. Of two hundred and fifty-nine women who were married at the time of the operation, and who have since kept him supplied with annual slips from their family Bibles, twenty-three have had one or more children. Even as regards the twenty-five women from whom both ovaries were removed, the author "has not been able to trace any peculiarity in their subsequent condition . . . as compared with those from whom only one ovary was removed, except that in only one case has there been anything like menstruation after recovery." In a professional point of view, however, a music-teacher was much the gainer by the double operation. "My voice is stronger," she writes: "I can sing the upper notes with greater facility than formerly. I can sing from A up to C natural." To those *prime donne* who wish to warble nimbly in the upper register, we gratuitously throw out this hint. The time may yet be when the capricious Opera shall impose upon its priestesses that sacrifice which a cruel dilettanteism exacted from pontifical sopranists; when, by the aid of the minor incision and the clamp, the madrigals of Pergolesi and the canzonets of the old composers shall be sung in their original key.

In order to establish the claim "that ovariotomy originated with British surgery, on British ground," much is made of a certain Dr. Robert Houstoun, who, in 1701, opened a woman's belly to the extent of two inches with "an imposthume lancet," and, with a "strong firsplinter" wrapped with "some loose lint about the end of it," drew out some hydatids, and "about two yards in length of a substance thicker than any jelly." On another page, it is true, the author very grudgingly admits that "no one can dispute the validity of the direct claims of McDowell as designedly the first rational ovariotomist." But the edge of this compliment is blunted by a most unhappy-looking portrait of the "first rational ovariotomist," and by the saving clause that, "at the same time, it must be maintained that the still greater merit of pointing out the absence of any physiological reasons against the operation, the possibility of its safe performance in the human female, and the class of cases in which it ought to be admissible, is due to a series of eminent British surgeons."

One grave fault lowers the standard of this book; and that is an offensive egotism. The hilarity of success is too boisterous. The author's pats and others' slaps upon his shoulder are too audible and too frequent to be in good taste. His reviewers would cheerfully have done this for him, but he has been beforehand with them there; he has done it himself. Perhaps this, however, is the last British fashion; for we are told by the London *Times* that, with reference to his last novel, the late Lord Lytton "had himself expressed the very highest opinion of its merits."

By the lack of an index the usefulness of this book is much hampered; and this is not the only mark of haste. The style is by no means elegant, and not always grammatical. It is, further, too often dashed with trite scraps of Latin, and too often marred by mawkish attempts at humor and at fine writing. Skylarking with one's mother-tongue is permissible in a boarding-school girl; unpardonable in one of the princes of science. Not in motley, but in robes of purple should royalty be clad. Out of many examples of these failings we select the following: "British experience is echoed from the Continent. Neither climatic influences nor constitutional peculiarities seem to assist the physician in his efforts at cure. One might expect something different from the impetuous science of the South, acting upon the warm-blooded victims of ovarian disease, in a climate whose morbific and curative alternations are almost phantasmagoric, or from the persistent therapeutical batteries and sieges of the North, opposed to the passive resistance of phlegmatic habits. . . . The fact that vascular excitement and congestion aggravate every symptom naturally enforces in a question of matrimony the Polichinellian advice, 'Don't.'" Chapters sixth and eighth contain many choice specimens of a style which has hitherto been consecrated to the literature of table-turning and joint-cracking circles.

As a good illustration of the author's mannerism, and of the shifts that national vanity will resort to, we should like to transcribe in full a very curious argument, showing how McDowell snatched the laurel of priority from the British Lion; but, as it extends somewhat over a page, we shall merely give the thread of it. "In this country, such is the sacredness of human life, even when threatened by fatal disease, . . . that men even of the stamp of the Hunters and the Bells naturally shrank from the responsibility . . . of adopting and inaugurating it [ovariotomy] as a part of legitimate surgery; and elected rather, in the modesty of their greatness,—'*stare decisis et non quietâ movere*,'—to content themselves by tending with careful pains the last flickerings of life in their confiding patients, and soothing as best they might their prolonged sufferings, than, as it would seem to them, proceed to the choice and immolation of the sacrificial victims demanded as the inevitable price of the safety of future generations, or the aggrandizement of their own fame. And it must be remembered that . . . they [the patients] were not buoyed up, as modern women are, by the histories and promises of painless extirpations under chloroform or methylene; and that, without anything like mawkish sentimentalism, surgeons themselves had to encounter the '*peine forte et dure*' of their suppressed sympathy, and nerve themselves up to the infliction of the most deliberate and tedious eviscerative vivisection. The disease was looked upon as a mystery, and its ending in death as a matter of course; and, instead of being accompanied, as we now see it, by fretful resistance and chafings to escape, it only led—'*Deo duce, medico comitante*'—to stolid endurance or religious submission; and, on the part of the profession, to an '*ad normam*' attendance, rather ceremonial than remedial. But McDowell *was* a free man in a new country, clear from the conventional trammels of Old-World practice, *found* his patients in the most favorable conditions of animal life, *seems* to have had one of those incomprehensible runs of luck upon which a man's fate and reputation so often turn———and was happy . . . in finding suitable time, place, persons, and opportunity for testing the exercise of his Young-American

'*felix temeritas*,' based upon and guided by the Scotch '*perfervidum ingenium*' of his tutor, Bell."

Five quotations from the Latin and one from the French within the compass of a page, and the rest English on stilts! After reading this and much like it, we feel constrained to cap the above quotations by ejaculating, in a literary sense, the petition from the litany of our Anglo-Saxon forefathers,—"A furore Normanorum libera nos, Domine."

BOOKS AND PAMPHLETS RECEIVED.

Criminal Responsibility of Epileptics. By M. G. Echeverria, M.D. (Reprint from the *American Journal of Insanity*, January, 1873.) 8vo, pp. 85.

Report of the Pennsylvania Hospital for the Insane, for the Year 1872. By Thomas S. Kirkbride, M.D., Physician-in-Chief and Superintendent. 8vo, pp. 70. Philadelphia, 1873.

First Annual Report of the State Board of Health of Minnesota. January, 1873. 8vo, pp. 102.

Fifth Annual Report of the Board of Managers of the Philadelphia Orthopædic Hospital for Treatment of Bodily Deformities and Diseases of the Nervous System. Small 8vo, pp. 23. Philadelphia, 1873.

Fifth Annual Report of the Pennsylvania Society for the Prevention of Cruelty to Animals. 8vo, pp. 32. Philadelphia, 1873.

What Women Should Know. A Woman's Book about Women, containing Practical Information for Wives and Mothers. By Mrs. E. B. Duffey. Small 8vo, pp. 320. Philadelphia, J. M. Stoddart & Co., 1873.

GLEANINGS FROM OUR EXCHANGES.

INTERRUPTED MICTURITION IN CHILDREN (Englisch: Aertzl. Verein in Wien; from *Wiener Med. Presse*, December 1, 1872).—Excluding those cases where no urine is secreted, Dr. Englisch first spoke of cases in which the pathologico-anatomical changes interfere with the voiding of urine already secreted. This may occur from closure of the prepuce, and of the dermoid opening of the urethra,—the most usual cause,—or by a closure of the vesical opening of the urethra, of the opening of the ureter into the bladder, or the stoppage of the ureter,—a rare occurrence,—as, for example, by a foreign body.

If the urethra is closed, it is closed through a considerable portion of its length. There are frequently valves in the urethra, generally in the upper part, and there may also be valves in the neck of the bladder, and even in the ureters. They interfere with the passage of the urine only when they are broad, and present their free edge towards the bladder. The stoppage of urine by valves alters the shape of the bladder so that it may be easily detected in the cadaver. The organ becomes egg-shaped, its walls are thickened, the mucous membrane is thrown into numerous folds, and the ureters and pelvis of the kidney are widened, and nephritis and atrophy of the kidneys are present.

The voidance of the urine is rarely entirely suspended; it is generally only impeded, especially when the openings and calibre of the urinary passages are only narrowed, or when tumors are situated in them.

The narrowing may also be caused by inflammatory processes in the urethra.

Congenital phymosis may render micturition difficult, especially in those children where the foreskin has united with the glans penis, in such a way that the opening is covered by the prepuce.

In hypospadias a narrowing of the external urethral opening is generally present. If tumors are present, we shall find that the cystic and polypous forms give the most trouble; the former, though smaller, provoke the most irritation. They may be entirely new growths, or they may be the results of retention of secretions, as, for example, the dilatation of the glands of Littré in the female urethra, and the distention of the sinus pocularis in the male. Such "retention-cysts" the author found always in the median line, on the inferior wall of the urethra, at the point of junction between the pendulous portion and the bulbous, whereas in adults the lacunæ Morgagni were dilated by the retention.

Hyperplasia of the prostate gland is also a frequent cause of difficult micturition, and the author believes that a congenital hypertrophy of this gland often exists. Among pathological causes, external to the urethra, may be mentioned peri-urethritis caused by the irritative effects of coxitis upon the cellular tissue.

If concrements are in the bladder, the effects of the previously described obstructions are increased. The chief symptom is the dilatation of that part which lies behind the obstruction. If the obstruction is anterior to the fascia perinæi propria, swelling and erection accompany the voidance of the urine, and continue a little while after it is accomplished.

If the obstruction lies deeper, the fulness of the bladder becomes the cause of pain. The little sufferers cry aloud at each endeavor to pass the urine, draw up their lower extremities, and move their pelvis about restlessly. By a continued distention of the bladder, nephritis is at last produced,—the real cause of which is often overlooked in these cases by the post-mortem examiner. Catheterization should be performed with an elastic catheter. These obstructions occur less frequently in the later years of life; they usually occur immediately after birth. The bladder in children shows a marked tendency to hypertrophy.

PROGRESSIVE MUSCULAR ATROPHY.—M. Hanot has recently had under observation, in the Hôpital Salpétrière, two cases of progressive muscular atrophy occurring in women affected with general palsy. One of the patients died, and M. Hanot found that the cells of the anterior columns of the cord, particularly in the cervical region, had undergone disintegration. To this well-marked and distinctly limited lesion there was conjoined diffused sclerosis of the posterior columns, which, however, was less distinctly marked, and somewhat doubtful. Hence, in addition to diffused sclerosis, described by Magnan and Westphal, there existed, in the present cases, progressive muscular atrophy, with changes in the motor elements of the spinal cord.

M. Charcot, apropos of what was said by M. Hanot, revives the question of nutritional disturbances, and the physiological interpretation that may be bestowed upon them. Samuel originated the idea of the existence of trophic nerves and endowed them with special functions, but anatomy and physiology have dealt justly with the invention, and we have now gotten rid of this new kind of nerves. What can be substituted in their place? Clinical facts are crowding together, and demand explanation. M. Charcot has taken upon himself the risk of proposing one, by throwing out a hypothesis which accords with what we know of the physiology of nerves. It is known that M. Vulpian, by joining the lingual and hypoglossal together, has proved that the motor and sensory fibres possess but one and the same function,—viz., that of transmitting the nervous current. The distinguishing point between them

is their different mode of termination in the centres and at the periphery. If, then, the nerve-fibres are capable of transmitting centripetal and centrifugal waves, it is not improbable that an excitation of the sensory fibres, propagated to the periphery, may irritate the terminal filaments with their delicate organization, described by Pacini, Meissner, Langerhans, and Biésiadecki, and cause various changes, such as zona, ulcerations, etc.

DOUBLE LUXATION OF THE CLAVICLE (by Dr. Col).—The *Mouvement Médical* of November 9, 1872, contains the following report of a curious case of double luxation of the clavicle, taken from the *Gazette des Hôpitaux*. On the 29th of May, a girl seventeen years of age, while unloading a heavy dray, was jammed, by a sudden movement of the horses, between the shaft and a wall. By violent pressure on both shoulders the chest was compressed, and was at the same time rotated by the gliding of the shaft on the left shoulder, while the right was fixed against the wall.

M. Col, who saw the girl ten minutes after the occurrence of the accident, found that the left clavicle was dislocated at both of its extremities, producing a marked prominence at the acromion and at the sternum. The entire bone had been driven forwards, as it happens to the stone when a cherry is squeezed between the thumb and the index-finger.

The apparatus employed to keep the shoulder back and the ends of the bone in place consisted of a towel binding the elbow to the trunk, and three pads,—one of good size for the axilla, and two smaller ones for the extremities of the clavicle. On the 3d of July the dressing was entirely removed; the patient had some difficulty in moving her left arm, but on the 20th the movements were perfectly free, and the girl was again able to assist her father in the arduous duties of drayman.

MISCELLANY.

AMERICAN MEDICAL ASSOCIATION.—The twenty-fourth annual session of this body will be held in St. Louis, Mo., on May 6, 1873. Dr. T. M. Logan, of Sacramento, Cal., is the President-elect.

Physicians desiring to present papers before the Association should observe the following rule:

"Papers appropriate to the several sections, in order to secure consideration and action, must be sent to the Secretary of the appropriate section at least one month before the meeting which is to act upon them. It shall be the duty of the Secretary to whom such papers are sent, to examine them with care, and, with the advice of the Chairman of his Section, to determine the time and order of their presentation, and give due notice of the same. . . . ."

The following is a list of the Secretaries of Sections:

Chemistry and Materia Medica,—Ephraim Cutter, Boston, Mass.

Practice of Medicine and Obstetrics,—Benjamin F. Dawson, New York, N.Y.

Surgery and Anatomy,—W. F. Peck, Davenport, Iowa.

Meteorology and Epidemics,—Elisha Harris, New York, N.Y.

Medical Jurisprudence, Hygiene, and Physiology,—A. B. Arnold, Baltimore, Md.

Psychology,—John Curwen, Harrisburg, Pa.

It is proposed so to amend the By-laws that, instead of a report on Medical Education, on Medical Literature, and on Climatology and Epidemic Diseases, there shall be annually delivered before the Association, at its general meetings, an address in Medicine, an address in Surgery, and an address in Midwifery, or the Diseases of Children, the lecturers to be appointed this year by the President, afterwards by the Committee on Nominations.

Secretaries of all medical organizations are requested to forward lists of their delegates, as soon as elected, to the Permanent Secretary, W. B. Atkinson, 1400 Pine Street, Philadelphia.

STILL CHARTERED.—*The Evening Telegraph* of March 10 contained the following item:

"Recently Judge Agnew, in the Supreme Court, gave the following decision in a case brought against the Eclectic College:

"The charter of the Eclectic Medical College of Pennsylvania was granted by act of Assembly in 1850, before the amendment of the Constitution in 1857. It contains no power of repeal. That such a charter is a contract between the State and the corporators, as to the franchises granted, is well settled: Iron City Bank *vs.* City of Pittsburg, 1 Wright, 340. Without a judicial proceeding to declare a forfeiture of the charter upon cause shown, there is no power to repeal it summarily: Erie and North East Railroad Company *vs.* Casey, 2 Casey, 301; same *vs.* same, 1 Grant, 271; Com. *vs.* Pittsburg and Connellsville Railroad Company, 8 P. F. Smith, 46–7. The act of 22d March, 1872, is the act of but one party to the contract, without a power reserved in the contract to authorize the State to do the act, and, being without the consent of the other party (the corporators), is nugatory, because of the Constitution of the United States, article 1, section 10, and the Constitution of the State, article 9, section 10, forbidding the passage of laws impairing the obligation of contracts. The recital in the preamble of the act of 1872, that it had been ascertained, by evidence produced before a committee of the Senate, that the Eclectic Medical College had been guilty of unlawful, discreditable, and dangerous acts, on which the repeal was thereupon declared, does not help the case. The committee had no judicial power, and could not turn itself into a court of justice to take jurisdiction, summons and try the corporation for its alleged offences. It was but a portion of the legislative body itself, charged with a function merely auxiliary to legislation. Its judgment was no more than the judgment of the body conferring upon it the power of inquiry. The act of 1872, repealing the charter, was therefore without legislative force, and void. The corporation is entitled to a trial in due course of law, to ascertain its breach of duty, before its charter can be taken away. A franchise is a valuable privilege, and is property in the contemplation of law; and the body possessing it is as much entitled to a judicial determi-

nation of its right, or want of right, to hold it, as a natural person is of his right to his lands or his goods. The defendant is therefore entitled to judgment upon his demurrer.

"Demurrer sustained, and judgment thereupon for the defendant, that he go without day, and be paid his costs."

THE lectures in the schools of medicine and pharmacy at Montpellier, in France, suspended recently by government on account of certain irregularities on the part of some of the students, were resumed on the 14th of February; only those pupils being admitted, however, who were provided with tickets by the authorities. No clear statement of the exact cause of the trouble has as yet been made public.

SUICIDE.—On the morning of March 5, Dr. Alfred E. Walker, a promising young physician of New Haven, Connecticut, shot himself dead in his room at the New Haven Hotel. The act resulted from chronic melancholy, almost amounting to insanity, under which he had for some time been suffering.

CORRECTION.—Our recent announcement of a new edition of the "United States Dispensatory" was premature, as the work of revision is one of great labor, requiring much time for its performance. We should have stated that the material for the revised edition was being collected.

ACCORDING to the "Philadelphia Medical Register," lately issued, there are six hundred and ninety-nine regular physicians in the city. About fifty of these have retired from active practice.

APPOINTMENT.—Dr. A. W. Mathews, of Media, has been appointed by Governor Hartranft quarantine physician to the port of Philadelphia, to succeed Dr. John L. Gihon, removed.

DR. SOCRATES N. SHERMAN, a leading physician and public man of Ogdensburg, New York, died early in February, at the age of 71.

MORTALITY OF PHILADELPHIA.—The interments reported at the Health Office for the week ending March 8, 1873, were 332; 169 adults, and 163 minors. 7 were of bodies brought from the country; making the mortality of the city 325. Among the assigned causes of death were:

Consumption of the Lungs	43
Other Diseases of the Respiratory Organs	46
Diseases of the Circulatory Apparatus	12
Diseases of the Brain and Nervous System	54
Diseases of the Digestive Apparatus	23
Zymotic Diseases (12 from Scarlet Fever, 1 from Small-pox)	36
Typhoid Fever	5
Casualties	6
Cancer	5
Diseases of the Urinary Organs	7
Pyæmia	2
Rheumatism	2
Tumors	2
Debility (including "Inanition" and "Marasmus")	37
Still-born	20
Old Age	15

(The interments reported for the week ending March 9, 1872, were 443.)

THE meteorological record kept at the Pennsylvania Hospital was as follows:

		THERMOMETER.		BAROMETER.
		Max.	Min.	(2 P.M.)
Mar.	2	42.0°	27.5°	30.17 in. (Snow.)
"	3	37.0	17.0	29.83 in. (Snow.)
"	4	24.0	8.0	30.33 in.
"	5	25.0	10.0	30.70 in.
"	6	33.0	15.0	30.77 in.
"	7	44.0	23.5	30.51 in.
"	8	47.0	32.5	29.99 in.

The mean temperature of the month of February was 30.57°.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM FEBRUARY 25, 1873, TO MARCH 10, 1873, INCLUSIVE.

VOLLUM, E. P., ASSISTANT-SURGEON.—The leave of absence granted by S. O. 25, Department of the Platte, February 15, 1873, extended thirty days. S. O. 22, Military Division of the Missouri, February 24, 1873.

POPE, B. F., ASSISTANT-SURGEON.—To accompany 7th Regiment of Cavalry to Fort Randall, Dakota Territory, and, after completion of this duty, return to Louisville, Kentucky, reporting to Medical Director, Department of the South. S. O. 40, Department of the South, February 26, 1873.

CAMPBELL, JOHN, SURGEON.—Granted leave of absence for thirty days. S. O. 41, Department of the East, March 3, 1873.

MACKIN, CHARLES, ASSISTANT-SURGEON.—Assigned to duty at Yorkville, South Carolina. S. O. 45, Department of the South, March 4, 1873.

NAVY NEWS.

LIST OF CHANGES IN THE MEDICAL CORPS OF THE NAVY, FROM FEBRUARY 1, 1873.

Medical Director W. S. W. RUSCHENBERGER,—Waiting orders.

Medical Director J. M. FOLTZ,—To Naval Hospital, Philadelphia.

Medical Director WILLIAM MAXWELL WOOD,—As Inspector-General of Hospitals and Fleets.

Surgeon HENRY C. NELSON,—As Recorder of Naval Medical Board.

Medical Inspector SAMUEL F. COWES,—To Navy Yard, Portsmouth, New Hampshire.

Medical Inspector ALBERT L. GIHON,—To special duty, Bureau of Medicine and Surgery.

Medical Inspector EDWARD SHIPPEN,—Waiting orders.

P. A. Surgeon HENRY STEWART,—Naval Station, New Orleans.

Surgeon F. E. POTTER,—Receiving Ship, Portsmouth, New Hampshire.

Surgeon SOMERSET ROBINSON,—League Island Navy Yard.

P. A. Surgeon H. M. RUNDLETT,—To Iron-clad "Terror."

Surgeon J. H. CLARK,—Waiting orders.

Assistant-Surgeon S. W. LATTA,—Waiting orders.

Surgeon A. A. HOEHLING,—Sick leave.

Surgeon THOMAS C. WALTON,—To U.S.S. "Juniata."

Assistant-Surgeon H. C. ECKSTEIN,—Ordered home.

Assistant-Surgeon EDWARD EVERS,—To U.S.S. "Narragansett."

Surgeon B. F. GIBBS,—To U.S.S. "Richmond."

Assistant-Surgeon E. C. THATCHER,—Resigned.

Medical Inspector ALBERT L. GIHON,—To European Station, as Surgeon of the Fleet, on June 1.